A Centers' Brief Report*

Integrating Agenda for Mental Health in Schools into the Recommendations of the President's New Freedom Commission on Mental Health

March, 2004

Abstract: It is long been acknowledged that psychosocial and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. This reality is reflected in the aims of the *No Child Left Behind Act* and the *Individuals with Disabilities Education Act.* And, it is consonant with the goals and recommendations of the *President's New Freedom Commission on Mental Health*. Indeed, these initiatives reflect a shared agenda and must coalesce in school improvement policies and initiatives in ways that more wisely invest and use sparse resources. In pursuit of a shared agenda, existing resources can be deployed and redeployed in ways that enhance equity with respect to availability, access, and effectiveness.

There are about 90,000 schools in the U.S.A. In a real sense, schools are primary care and public health settings, and thus, school staff are primary care providers and agents for public health, although most don't identify as such. Moreover, our society calls on schools to serve all students without regard to disorder, disability, ethnicity, economic status, gender identity, and so forth. As a result, efforts to transform how mental health is delivered in this country need to include a specific emphasis on enhancing the focus on mental health in schools. To this end, this brief highlights ways in which the *President's New Freedom Commission on Mental Health*'s recommendations apply to mental health in schools. As conceived here, mental health in schools is (a) *part of* essential student support systems that enable students to learn so that schools can achieve their mission and (b) a fundamental facet of the initiative to transform the mental health system.

Preface

As the *President's New Freedom Commission on Mental Health* recognizes, any effort to enhance interventions for children's mental health must involve schools (see Appendix A). Indeed, school involvement is key to the transformation of how mental health interventions are delivered in the U.S.A. Fortunately, schools already provide a wide range of programs and services for all students who are not succeeding, and many of these interventions are relevant to mental health and psychosocial concerns. However, schools could and will need to do much more if the mandates of the *No Child Left Behind Act* and the *Individuals with Disabilities Education Act* are to produce the benefits the public desires.

In 1959, NIMH published a seminal document highlighting the importance of mental health in schools. Building on the following 35 years of work, a federal initiative to enhance mental health in schools was initiated in 1995 by the U.S. Department of Health and Human Services (see Appendix B). This initiative is helping clarify agenda for intervention research, policy, training, and technical assistance that are essential to improving children's mental health.

The following brief was prepared by the staff of the two national centers the DHHS initiative created to advance mental health in schools.[1] The document incorporates the research, training, and technical assistance activity of both centers. It also reflects the goals of *Healthy People 2010,* and the ideas set forth in *Bright Futures, Mental Health.* Moreover, it integrates input from the wide range of stakeholders across the country with whom the centers work. As a result, this brief draws on what has been learned over many years, in many contexts, and from many sources.

The specific intent here is to apply the extant body of knowledge related to mental health in schools in ways that will contribute to operationalizing the recommendations of the President's New Freedom Commission on Mental Health. The underlying message is that efforts to transform how mental health interventions are delivered can and should capitalize on the needs of and opportunities presented by schools. Three topics are covered from the perspectives of enhancing mental health in schools:

- Why Mental Health in Schools is an Imperative

- What Needs to be Done to Meet the Imperative

- Where All This Fits into the New Freedom Commission's Recommendations

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[1]The two centers are: the Center for Mental Health in Schools at UCLA (co-directed by Howard Adelman and Linda Taylor) and the Center for School Mental Health Assistance at the University of Maryland, Baltimore (directed by Mark Weist). Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Integrating Agenda for Mental Health in Schools into the Recommendations of the President's New Freedom Commission on Mental Health

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Why is Mental Health in Schools an Imperative?

For the most part, the usual answer to this question focuses on either or both of the following points:

- accessing students (and their families) who need mental health services is facilitated by contact through and at schools

- addressing psychosocial and mental and physical health concerns is essential to the effective school performance of some students

Inherent in both answers is the goal of enhancing the nature and scope of mental health interventions to fill gaps, enhance effectiveness, address problems early, and reduce stigma.

Point 1 typically reflects the perspective and agenda of agencies and advocates whose mission is to improve mental health services. The second point reflects the perspective and agenda of student support professionals and some leaders for school improvement.

Efforts to advance the imperative for mental health in schools must strive to coalesce the two agenda and broaden perspectives of mental health to encompass a full continuum of interventions that integrate school and community resources. To do so requires an appreciation of the oft-voiced public concern that schools cannot be responsible for meeting every need of their students.

Education is the mission of schools, and policymakers responsible for schools are quick to point this out when they are asked to do more, especially when the focus is on mental health. It is not that they disagree with the idea that healthier students learn and perform better. It is simply that prevailing school accountability pressures increasingly have concentrated policy on instructional practices – to the detriment of all matters not seen as *directly* related to raising achievement test scores. Those concerned with enhancing mental health in schools must accept the reality that schools are not in the mental health business. Then, they should develop an understanding of what school leaders currently are doing to achieve their mission and clarify how agenda for mental health in schools help accomplish that mission..

Given all this, as a general rationale for making mental health in schools an imperative, it is useful to begin with the view of the Carnegie Council Task Force on Education of Young Adolescents (1989) which states:

> *School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.*

> **Conceiving mental health *as part of* essential student supports that enable students to learn makes it an imperative for schools as they strive to achieve their mission.**
>
> From this perspective, the recommendations of the President's New Freedom Commission can coalesce with school improvement policy, especially (a) the aims of the *No Child Left Behind Act* (particularly the goals of closing the achievement gap and addressing dangerous schools) and (b) the changes that will be forthcoming as a result of the upcoming reauthorization of the *Individuals with Disabilities Education Act.*

Mental Health in Schools: Meeting the Imperative

It is one thing to provide a rationale that stresses mental health in schools is an imperative; it is quite another thing to frame how the imperative should be met. From the perspective of the mission of schools, it is insufficient to frame the work only in terms of (a) screening and diagnosing psychopathology, (b) providing clinical services, and (c) connecting community mental health providers to schools. These are, indeed, all fundamental to improving mental health, but the framework for making the case that mental health *in schools* is an *imperative* must be more comprehensive.

Making the case requires proceeding in ways that

- *define mental health broadly* – i.e., encompass the agenda for mental health *in schools* within the broad context of the psychosocial and mental health concerns encountered each day at schools – including an emphasis on strengths as well as deficits; also include an emphasis on the mental health of students' families and school staff

- *enhance partnerships among schools, communities, and the home* – e.g., focus on coalescing and enhancing the roles of schools/communities/homes in addressing emotional, behavioral, and learning problems

- *confront equity considerations* – e.g., stress the role mental health in schools can play in ensuring all students have an equal opportunity to succeed at school

- *address the related problems of marginalization, fragmentation, and counterproductive competition for sparse resources* – i.e., focus on coalescing policy, agencies, organizations, and daily practice

- *address the challenges of evidence-based strategies and achieving results* – e.g., stress ways to build on current in-school practices using a science-base (see Appendix C)

It is long been acknowledged that psychosocial and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. This reality is reflected in the aims of the *No Child Left Behind Act* and the *Individuals with Disabilities Education Act.* And, it is consonant with the goals and recommendations of the *President's New Freedom Commission on Mental Health*. Indeed, these initiatives reflect a shared agenda and must coalesce in school improvement policies and initiatives in ways that more wisely invest and use sparse resources.

With a shared agenda in mind, mental health in schools is conceived as (a) *part of* essential student support systems that enable students to learn so that schools can achieve their mission and (b) a fundamental facet of the initiative to transform the mental health system. In pursuit of a shared agenda, existing resources can be deployed and redeployed in ways that enhance equity with respect to availability, access, and effectiveness.
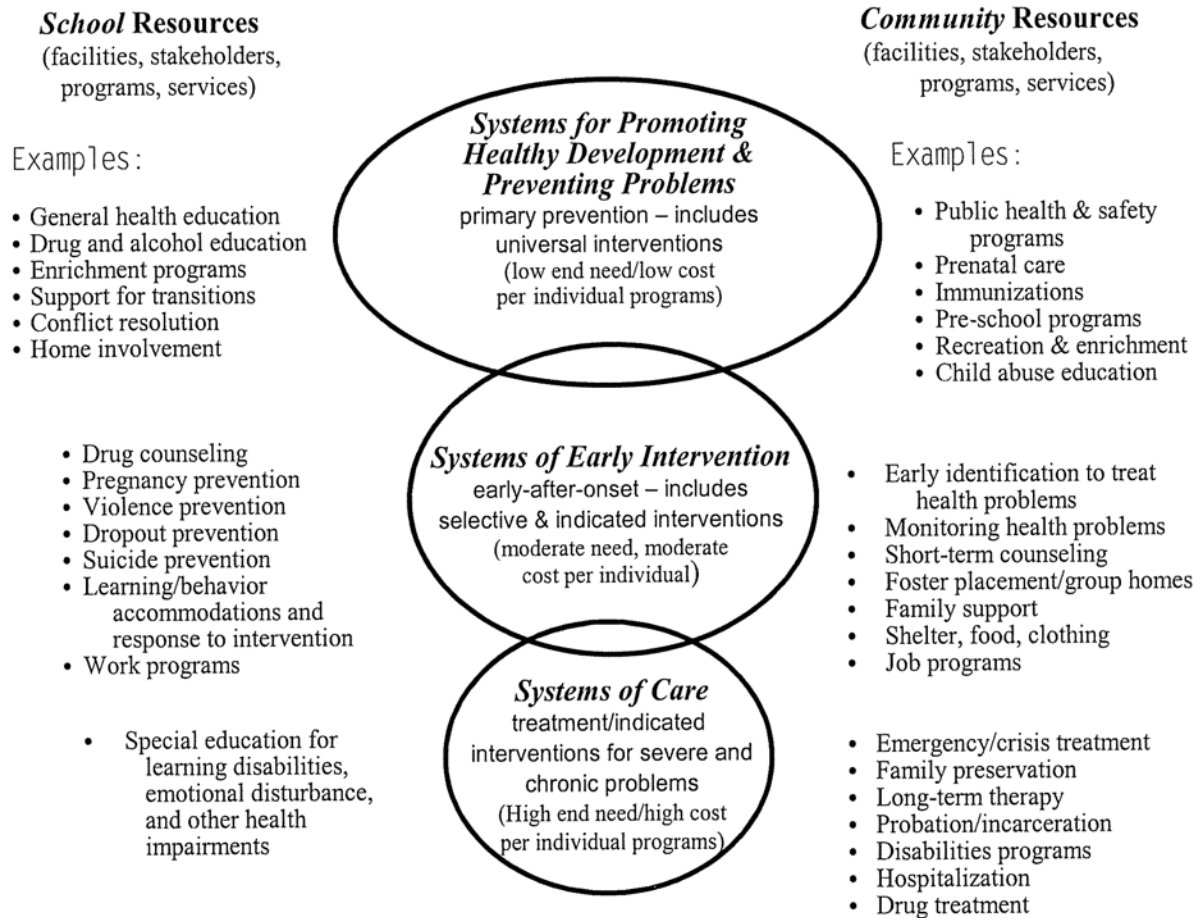
From the above perspective, the New Freedom Commission's recommendations can be operationalized to emphasize how mental health in schools can focus on:

- promoting social-emotional development, preventing mental health and psychosocial problems, and enhancing resiliency and protective buffers

- intervening as early after the onset of emotional, behavior, and learning problems as is feasible and to address severe and chronic problems

- addressing systemic matters at schools that affect both student and staff well-being, such as practices that engender bullying, alienation, student disengagement from classroom learning, and staff burnout

- establishing guidelines, standards, and accountability for mental health in schools in ways that confront equity considerations

- building the capacity of all school staff to address emotional, behavioral, and learning problems and promote healthy social-emotional development

- drawing on all empirical evidence as an aid in developing a comprehensive, multifaceted, and cohesive continuum of school-community interventions to address emotional, behavioral, and learning problems (see Figure 1)[2]

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[2] Evidence supporting MH in schools comes from a variety of sources. Some of the science base is synthesized in lists of empirically supported/evidence based practices for school-aged children and adolescents (an annotated summary of these lists is online at http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf). Another synthesis has been compiled by the Center for Mental Health in Schools at UCLA and is summarized in a Center Brief entitled: *Addressing Barriers to Student Learning & Promoting Healthy Development: A Usable Research-Base* (available online at http://smhp.psych.ucla.edu/pdfdocs/briefs/BarriersBrief.pdf).

Figure 1. Interconnected Systems for Meeting the Needs of All Children

» Providing a *Continuum of School-community Programs & Services*

» Ensuring use of the *Least Intervention Needed*

School Resources
(facilities, stakeholders, programs, services)

Examples:

- General health education
- Drug and alcohol education
- Enrichment programs
- Support for transitions
- Conflict resolution
- Home involvement

- Drug counseling
- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Suicide prevention
- Learning/behavior accommodations and response to intervention
- Work programs

- Special education for learning disabilities, emotional disturbance, and other health impairments

Systems for Promoting Healthy Development & Preventing Problems
primary prevention – includes universal interventions
(low end need/low cost per individual programs)

Systems of Early Intervention
early-after-onset – includes selective & indicated interventions
(moderate need, moderate cost per individual)

Systems of Care
treatment/indicated interventions for severe and chronic problems
(High end need/high cost per individual programs)

Community Resources
(facilities, stakeholders, programs, services)

Examples:

- Public health & safety programs
- Prenatal care
- Immunizations
- Pre-school programs
- Recreation & enrichment
- Child abuse education

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization
- Drug treatment

Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems* of *prevention, systems* of *early intervention*, and *systems of care.*

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*Such collaboration involves horizontal and vertical restructuring of programs and services
(a) within jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters of schools)
(b) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies

Where All This Fits into the New Freedom Commission's Recommendations

There are about 90,000 schools in the U.S.A. In a real sense, schools are primary care and public health settings, and thus, school staff are primary care providers and agents for public health, although most don't identify as such. Moreover, our society calls on schools to serve all students without regard to disorder, disability, ethnicity, economic status, gender identity, and so forth. As a result, efforts to transform how mental health is delivered in this country need to include a specific emphasis on enhancing the focus on mental health in schools. To this end, the following section highlights ways in which the Commission's recommendations apply to mental health in schools.

Commission Goal 1 - **Understanding that mental health is essential to overall health**

Commission Recommendation 1.1
Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools are key venues for campaigns and prevention programs.* An enhanced focus on mental health in schools provides both natural opportunities and formal avenues to promote efforts to reduce stigma and prevent not only suicide but a range of other related mental health and psychosocial problems. Natural opportunities occur each day at school as students interact with each other and staff. Formal avenues occur through integration into both regular and special education curricula, including prevention programs, specialized interventions for problems, and as part of courses for social and emotional development and mental health education – all of which can counter bias, discrimination, harassment, bullying, and alienation. Schools also provide a conduit to families and community stakeholders for enhancing understanding about mental health.

Commission Recommendation 1.2
Addressing mental health with the same urgency as physical health.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools play a major role in shaping public attitudes over time.* As a universal socializing institution, schools are a key determiner of future public opinion. Over time, development of a comprehensive, multifaceted approach to mental health in schools not only can increase understanding, but could enhance appreciation of the need to address mental health with equivalent priority as is given to physical health in our society. Some evidence that this will be the case comes from the data generated from school-based health centers, where an enhanced appreciation of the need for and value of mental health assistance has been a consistent finding.

Commission Recommendation 2.1
Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools need and are in a position to involve consumers in quality individualized planning.* Schools already involve families in IEP development as part of their compliance with special education mandates. A beginning has been made to transform such ongoing assessment and planning to conform with the consumer and family driven principles of systems of care. Along with strengthening systems of care efforts, an enhanced focus on mental health in schools can extend systemic approaches to include young consumer and family driven individualized planning for interventions that are implemented early after the onset of a problem.

Commission Recommendation 2.2
Involve consumers and families fully in orienting the mental health system toward recovery.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools that enhance their focus on mental health are more likely to work with young consumers and families toward the goal of recovery.* Schools are under tremendous pressure to raise the achievement of all students. This provides a major incentive for them to do more than control externalizing behavior problems. By enhancing mental health in schools, schools will be able to work toward a youngster's recovery and contribute to the recovery of parents to enable them to support student progress. A key aspect in accomplishing all this will be enhanced partnerships with other interveners and the student and his or her family. Such partnerships are especially important in transition periods, such as when youngsters terminate involvement in special services or transition to adult services.

Commission Recommendation 2.3
Align relevant Federal programs to improve access and accountability for mental health services.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools currently can seek waivers to redeploy and braid federal education dollars to coordinate and enhance the impact of student support services.* For example, under the federal No Child Left Behind Act schools can redeploy a percentage of the federal funds they receive to enhance coordination of services. A similar provision exists in the Individuals with Disabilities Education Act. In addition, schools can seek waivers in order to braid together various sources of categorical program funding. As such opportunities also increase for community agencies, school and community resources can be braided. With the enhanced emphasis on coordinating and integrating resources, availability, access, and accountability will increase.

Connecting this Commission Recommendation with Mental Health in Schools

- *For a State Mental Health Plan to be comprehensive, it must addresss the interface with schools in a major systemic way.* See Figure 1.

Connecting this Commission Recommendation with Mental Health in Schools

- *Protecting and enhancing the rights of young people with mental illness requires a coordinated and integrated school and community approach.* Evidence of the need to address schools in this respect is seen in the fact that so many school systems currently are out of compliance with special education mandates, especially in terms of meeting mental health needs. An enhanced focus on mental health in schools can help address this system failure and also strengthen privacy protections and informed consent procedures.

Commission Goal 3 - **Eliminating Disparities in Mental Health Services**

Connecting this Commission Recommendation with Mental Health in Schools

- *School staff are mandated to upgrade their competence continuously and schools are working to address language barriers.* Increasingly, the emphasis in schools is on enhancing effectiveness with diverse populations. This is a key goal of the focus on disaggregating school accountability indices. Initiatives to enhance mental health in schools emphasize increasing system and staff capacity to eliminate disparities arising from lack of availability, access, and competence related to human diversity. Still, there are major deficiencies related to both the pre- and inservice training of student support staff and other mental health professionals who come into schools that must be addressed in the interest of enhancing quality.

Connecting this Commission Recommendation with Mental Health in Schools

- *Enhancing mental health in all schools is a key to enhancing availability and access in every community.* Schools serve all communities.

Commission Recommendation 4.1
    Promote the mental health of young children.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools increasingly are focusing on pre-schoolers and the special needs of students in primary grades.* Head start has always had a mental health focus; all pre-schools are concerned with promoting social and emotional development. Teachers of young children and other staff at their schools are critical elements in promoting mental health (or contributing to emotional and behavioral problems). They also are essential to early detection and referral. And, with an enhanced focus on mental health in schools, more student support programs and services can be available to prevent and address problems early after their onset.

Commission Recommendation 4.2
    Improve and expand school mental health programs.

Connecting this Commission Recommendation with Mental Health in Schools

- *Continue and expand the federal Mental Health in Schools Program.* See Appendix B.

- *Expand the federal mental health research agenda to enhance the focus on mental health in schools.* A strong research agenda is needed related to the interface between school and mental health policy, research, training, and practice.

- *Coalesce mental health-related federal categorical programs in schools.* The Safe Schools/Healthy Students initiative has pioneered an interagency approach that braids funds from three federal departments in ways that have improved and expanded mental health programs. A broader initiative is now needed to address the problems of so-called "silo" funding to schools within and across federal agencies. This should include integrating CDC's Coordinated School Health Program with a specific emphasis on enhancing school climate in ways that promote healthy (physical and mental) development. (Also, see school-related recommendation for 2.3 above.)

Commission Recommendation 4.3
    Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Connecting this Commission Recommendation with Mental Health in Schools

- *Substance abuse is a major concern in schools.* Because this is so, schools provide an invaluable venue for addressing co-occurring mental health and substance problems. Next to parents, teachers and student support staff are in a strategic position to detect problems early (and will do so as long as long as confidentiality concerns are addressed appropriately). And, by definition, an integrated intervention approach requires the involvement of school staff.

> *Commission Recommendation 4.4*
>   Screen for mental disorders in primary health care, across the lifespan, and connect to
>   treatment and supports.

Connecting this Commission Recommendation with Mental Health in Schools

- *School nurses, other student support staff, and the staff of school-based health centers should be viewed as providing primary health care.* Such personnel do and can play an even greater role in early detection and referral of mental health problems and in coordinating and integrating interventions at school and with community providers.

Commission Goal 5 - Delivering Excellent Mental Health Care and Accelerating Research

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> *Commission Recommendation 5.1*
>   Accelerate research to promote recovery and resilience, and ultimately to cure and
>   prevent mental illnesses.

Connecting this Commission Recommendation with Mental Health in Schools

- *Expand the federal mental health research agenda to accelerate the focus on mental health in schools.* There are many areas in need of extensive research. For example: research on resilience and protective buffers related to schools is still in its earliest stages; research on the outcomes of special education programs for emotional and behavioral problems has yet to identify approaches that have a high degree of lasting effectiveness; research related to replication and school districts scale-up of science-based prevention programs is needed.

> *Commission Recommendation 5.2*
>   Advance evidence-based practices using dissemination and demonstration projects and
>   create a public-private partnership to guide their implementation.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools increasingly are being called upon to use evidence-based MH practices.* In doing so, they have developed demonstration projects and various dissemination strategies. The next step is to focus on sustainability, replication, and scale-up strategies. Lessons learned from the current federal initiative for diffusing Comprehensive School Reform models will be instructive with respect to creating public-private partnerships. Also useful will be what has been learned from the extensive work across the country focused on developing school-community collaboratives.

Improve and expand the workforce providing evidence-based mental health services and supports.

Connecting this Commission Recommendation with Mental Health in Schools

- *Build capacity for incorporating science-based activity among student support staff and other mental health professionals who come into schools.* The current federal Mental Health in Schools Program has begun this process through the two national training and technical assistance centers it established. Obviously, such capacity building is a long-term concern, and one that must be institutionalized into pre- and in-service programs across the country.

Commission Recommendation 5.4
Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools must play a role in each of these areas.* School involvement is indispensible both as contexts and sources for child and adolescent samples. With an enhanced focus on mental health in schools, some of the barriers to conducting such research can be reduced.

Commission Goal 6 - **Using Technology to Access Mental Health Care and Information**

Commission Recommendation 6.1
Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools already are involved in pioneering use of health technology and telehealth.* The next step is to evolve and sustain the demonstrations and develop replication and scale-up strategies.

Commission Recommendation 6.2
Develop and implement integrated electronic health record and personal health information systems.

Connecting this Commission Recommendation with Mental Health in Schools

- *Schools currently are in the process of revamping and computerizing their information management systems.* In response to the accountability demands of the No Child Left Behind Act (and the protections required by FERPA and HIPAA), school districts across the country are redesigning and computerizing their information management systems. The opportunity exists to influence the type of health data included and improve system connectivity with health and other agencies, while also enhancing privacy safeguards.

Concluding Comments

As the Commission noted, this is a time of sparse resources for public enterprises. Therefore, their report stresses the importance of "policy and program changes that make the most of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers, coupled with a strong measure of accountability." The aim is to more wisely invest and use sparse resources. The focus in this brief on mental health in schools is consistent with this aim.

Schools currently expend significant resources on student support programs and services that address behavioral and emotional problems. Such resources are deployed through piecemeal policies and are implemented in a fragmented manner. One focus of the federal Mental Health in Schools Program has been to address these problems so that resources are deployed and redeployed in ways that enhance equity with respect to availability, access, and effectiveness.

As the New Freedom Commission's recommendations are operationalized, the opportunity arises to further the agenda for schools to play a comprehensive role in transforming mental health in the U.S.A. Many stakeholders are ready to help make this a reality.

Appendices

A. Highlights of the Goals and Recommendations of the President's New Freedom Commission on Mental Health

B. Federal Mental Health in Schools Program

C. A Note About Building on Current In-School Practices

D. Guidelines, Standards and Accountability for MH in Schools

Appendix A

Goal 1. **Americans Understand that Mental Health is Essential to Overall Health.**

Recommendations:

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention

1.2 Address mental health with the same urgency as physical health

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Accompanying text from Commission Report Executive Summary:

"In a transformed mental health system, Americans will seek mental health care when they need it - with the same confidence that they seek treatment for other health problems. As a Nation, we will take action to ensure our health and well being through learning, self-monitoring, and accountability. We will continue to learn how to achieve and sustain our mental health.

The stigma that surrounds mental illnesses and seeking care for mental illnesses will be reduced or eliminated as a barrier. National education initiatives will shatter the misconceptions about mental illnesses, thus helping more Americans understand the facts and making them more willing to seek help for mental health problems. Education campaigns will also target specific audiences, including:

- Rural Americans who may have had little exposure to the mental health service system,
- Racial and ethnic minority groups who may hesitate to seek treatment in the current system, and
- People whose primary language is not English.

When people have a personal understanding of the facts, they will be less likely to stigmatize mental illnesses and more likely to seek help for mental health problems. The actions of reducing stigma, increasing awareness, and encouraging treatment will create a positive cycle that leads to a healthier population. As a Nation, we will also understand that good mental health can have a positive impact on the course of other illnesses, such as cancer, heart disease, and diabetes.

Improving services for individuals with mental illnesses will require paying close attention to how mental health care and general medical care systems work together. While mental health and physical health are clearly connected, the transformed system will provide collaborative care to bridge the gap that now exists.

Effective mental health treatments will be more readily available for most common mental disorders and will be better used in primary care settings. Primary care providers will have the necessary time, training, and resources to appropriately treat mental health problems. Informed consumers of mental health service will learn to recognize and identify their symptoms and will seek care without the fear of being disrespected or stigmatized. Older adults, children and adolescents, individuals from ethnic minority groups, and uninsured or low-income patients who are treated in public health care settings will receive care for mental disorders.

> **Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illnesses.**

The transformed mental health system will rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services. This is a basic principle for a recovery-oriented system of care."

Goal 2: **Mental Health Care is Consumer and Family Driven**

Recommendations

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance

2.2 Involve consumers and families fully in orienting the mental health system toward recovery

2.3 Align relevant Federal programs to improve access and accountability for mental health services

2.4 Create a Comprehensive State Mental Health Plan

2.5 Protect and enhance the rights of people with mental illnesses

Accompanying text from Commission Report Executive Summary:

"In a transformed mental health system, a diagnosis of a serious mental illness or a serious emotional disturbance will set in motion a well-planned, coordinated array of services and treatments defined in a single plan of care. This detailed road map – a personalized, highly individualized health management program – will help lead the way to appropriate treatment and supports that are oriented toward recovery and resilience. Consumer, along with service providers, will actively participate in designing and developing the systems of care in which they are involved.

An individualized plan of care will give consumers, families of children with serious emotional disturbances, clinicians, and other providers a valid opportunity to construct and maintain meaningful, productive, and healing relationships...

No longer will parents forgo the mental health services that their children desperately need. No longer will loving, responsible American parents face the dilemma of trading custody for care. Families will remain intact. Issues of custody will be separated from issues of care...

In this transformed system, stigma and discrimination against people with mental illnesses will not have an impact on securing health care...

The hope and the opportunity to regain control of their lives – often vital to recovery – will become real for consumers and families Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery."

Goal 3: **Eliminating disparities in mental health services**
   Recommendations
   3.1 Improve access to quality care that is culturally competent.
   3.2 Improve access to quality care in rural and geographically remote areas.

Accompanying Text from Commission Report Executive Summary:

"In a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location. Mental health care will be highly person, respecting and responding to individual differences and backgrounds. The workforce will include members of ethnic, cultural, and linguistic minorities who are trained and employed as mental health service providers. People who live in rural and remote geographic areas will have access to mental health professionals and other needed resources. Advances in treatments will be available in rural and less populated areas. Research and training will continuously aid clinicians in understanding how to appropriately tailor interventions to the needs of consumers, recognizing factors such as age, gender, race, culture, ethnicity, and locale..."

Goal 4: **Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice**
   Recommendations:
   4.1 Promote the mental health of young children.
   4.2 Improve and expand school mental health programs.
   4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
   4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

Accompanying Text from Commission Report Executive Summary:

"In a transformed mental health system, the early detection of mental health problems in children and adults - through routine and comprehensive testing and screening - will be an expected and typical occurrence. At the first sign of difficulties, preventive interventions will be started to keep problems from escalating. For example, a child whose serious emotional disturbance is identified early will receive care, preventing the potential onset of a co-occurring substance use disorder and breaking a cycle that otherwise can lead to school failure and other problems.

Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health problems, such as criminal justice, juvenile justice, and child welfare systems. Both children and adults will be screened for mental illnesses during their routine physical exams.

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening. Service providers across settings will also routinely screen for co-occurring mental illnesses and substance use disorders. Early intervention and appropriate treatment will also improve outcomes and reduce pain and suffering for children and adults who have or who are at risk for co-occurring mental and addictive disorders.

Early detection of mental disorders will result in substantially shorter and less disabling courses of impairment."

Goal 5: **Delivering excellent mental health care and accelerating research**
  Recommendations:
  5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
  5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
  5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
  5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Accompanying Text from Commission Report Executive Summary:

"In a transformed mental health system, consistent use of evidence-based, state-of-the-art medications and psychotherapies will be standard practice throughout the mental health system. Science will inform the provision of services and the experience of service providers will guide future research. Every time any American – whether a child or an adult, a member of a majority or a minority, from an urban or rural area – comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works. That care will be delivered according to the consumer's individualized plan....

Also benefiting from these developments, the workforce will be trained to use the most advanced tools for diagnosis and treatments. Translating research into practice will include adequate training for front-line providers and professionals, resulting in a workforce that is equipped to use the latest breakthroughs in modern medicine. Research discoveries will become routinely available at the community level. To realize the possibilities of advances in treatment, and ultimately in prevention or a cure, the Nation will continue to invest in research at all levels...."

Goal 6: **Using technology to access mental health care and information**
  Recommendations:
  6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
  6.2 Develop and implement integrated electronic health record and personal health information systems.

Accompanying Text from the Commission's Executive Summary:

"In a transformed mental health system, advanced communication and information technology will empower consumers and families and will be a tool for providers to deliver the best care. Consumers and families will be able to regularly communicate with the agencies and personnel that deliver treatment and support services and that are accountable for achieving the goals outlined in the individual plan of care. Information about illnesses, effective treatment, and the services in their community will be readily available to consumers and families...
An integrated information technology and communications infrastructure will be critical to achieving the five preceding goals and transforming mental health care in America. To address this technological need in the mental health care system, this goal envisions two critical technological components:
    >A robust telehealth system to improve access to care, and
    >An integrated health records system and a personal health information system for providers and patients..."

From the Final Report of The President's New Freedom Commission on MH
http://www.mentalhealthcommission.gov/reports/reports.htm

Federal Mental Health in Schools Program

Developed in 1995, the *Mental Health in Schools Program* focuses on enhancing the role schools play in mental health for children and adolescents. Specifically, the emphasis is on increasing the capacity of policy makers, administrators, school personnel, primary care health providers, mental health specialists, agency staff, consumers, and other stakeholders so that they can enhance how schools and their communities address psychosocial and mental health concerns.* Particular attention is given to prevention and responding early after the onset of problems as critical facets of reducing the prevalence of problems.

The initiative is sponsored by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB). When the program was renewed in 2000, HRSA and SAMHSA's Center for Mental Health Services braided resources to co-support the work. At that juncture, five-year awards were offered for two national-focused training and technical assistance centers. The two centers initially funded in 1995 successfully reapplied during the 2000 open competition. These centers are the *Center for Mental Health in Schools* at UCLA and the *Center for School Mental Health Assistance* at the University of Maryland, Baltimore.

The guiding principles and frameworks for the current work of the two Centers emphasize ensuring (1) mental *health* is understood in terms of psychosocial problems as well as disorders and in terms of strengths as well as deficits, (2) the roles of schools/communities/homes are enhanced and pursued jointly, (3) equity considerations are confronted, (4) the marginalization and fragmentation of policy, organizations, and daily practice are countered, and (5) the challenges of evidence-based strategies and achieving results are addressed. From this perspective, training and TA are designed not only to improve practitioners' competence, but to foster changes in the systems with which they work. Such activity also addresses the varying needs of locales and the problems of accommodating diversity among those trained and among populations served.

To these ends, the Centers enhance (a) availability of and access to resources to improve and advance MH in schools, (b) the capacity of systems/personnel, and (c) the role of schools in addressing MH, psychosocial, and related health concerns.

All this is accomplished through activities organized around six major tasks: (1) needs assessment (individuals and systems), (2) translating needs into a content focus and generating new ideas, frameworks, data, and knowledge, (3) gathering & developing materials – including development of guidebooks and training curricula, (4) designing & initiating effective delivery systems – strategies for direct assistance to practitioners, including newsletters, electronic networking, clearinghouse, and a consultation cadre; strategies to support those currently providing training; and strategies for stimulating policy for local training and TA, (5) providing a variety of TA and training venues, and (6) quality improvement strategies.

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*Examples of those using the Centers include administrators of national and state departments of education and state and county departments of health and mental health; directors of state school health and mental health programs and initiatives; executives of child and family commissions; administrators of national and regional resource centers and associations; members of boards of education; administrators, support staff, and teachers from school districts and regional education service areas; primary health care providers; members of community-based organizations; family members of mental health consumers; university center administrators and faculty; administrators of national education reform organization; staff of health law programs; public and private mental health practitioners; and agents representing school-based health centers, special education and treatment programs, and health system organizations; and much more.

Appendix C

A Note About Building on Current In-School Practices

It is, of course, not a new insight that psychosocial and mental health concerns must be addressed if schools are to function satisfactorily and students are to learn and perform effectively. It has long been acknowledged that a variety of such problems affect learning in profound ways. Moreover, these problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure. Because of this, school policy makers, have a lengthy, albeit somewhat reluctant, history of trying to assist teachers in dealing with problems that interfere with schooling.

Currently, there are about 90,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted policies and programs designed with a range of mental health and psychosocial concerns in mind. Some directly support school counseling, psychological, and social service programs and personnel; others connect community programs and personnel with schools. As a result, most schools have some programs to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. And, there is a large body of research supporting the promise of much of this activity.[3]

School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as out of classroom programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity. (See the next page for an Exhibit highlighting five major *delivery mechanisms and formats*).

School districts use a variety of their own *personnel* to address student support concerns. These may include "pupil services" or "support services" specialists such as psychologists, counselors, social workers, psychiatrists, and nurses, as well as a variety of related therapists. Such specialists tend to focus on students identified as problems or as having problems. Their many *functions* can be grouped into: (1) direct services and instruction, (2) coordination, development, and leadership related to programs, services, resources, and systems, and (3) enhancement of connections with community resources. In keeping with this last function, the focus often is on linking and collaborating with community agencies and programs to enhance resources and improve access, availability, and outcomes. Despite the range of activity, it remains the case that too little is being done in most schools, and prevailing approaches are poorly conceived and are implemented in fragmented ways.

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[3]For relevant references, go to
> (1) http://smhp.psych.ucla.edu/qf/references.htm
> (2) http://smhp.psych.ucla.edu/pdfdocs/briefs/BarriersBrief.pdf
> (3) http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf
> (4) http://csmha.umaryland.edu/

Exhibit: Delivery Mechanisms and Formats for MH in Schools

Five mechanisms and related formats have been categorized. They are:

1. *School-Financed Student Support Services* – Most school districts employ pupil services professionals such as school psychologists, counselors, school nurses, and social workers to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally-based and school-based services.

2. *School-District Mental Health Unit* – A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

3. *Formal Connections with Community Mental Health Services* – Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care ("wrap-around" services for those in special education). Four formats and combinations thereof have emerged:

- co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers partly financed by community health organizations
- formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
- formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
- contracting with community providers to provide needed student services

4. *Classroom-Based Curriculum and Special Out of Classroom Interventions* – Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:

- integrated instruction as part of the regular classroom content and processes
- specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
- curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems

5. *Comprehensive, Multifaceted, and Integrated Approaches* – A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions, as reflected in initiatives designated as expanded school mental health. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

- mechanisms to coordinate and integrate school and community services
- initiatives to restructure student support programs and services and integrate them into school reform agenda
- community schools

Guidelines, Standards and Accountability for MH in Schools

The following guidelines are based on a set of underlying principles for designing comprehensive, multifaceted, and cohesive approaches to Mental Health in schools (for specific rationale statements and references for each guideline, see http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf). Clearly, no school currently offers the nature and scope of what is embodied in the outline. In a real sense, the guidelines define a vision for defining and implementing MH in schools. They also provide the basis for developing standards, quality indicators, and accountability measures.

GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

1. General Domains for Intervention in Addressing Students' Mental Health

    1.1   Ensuring academic success and also promoting healthy cognitive, social, and emotional development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity)

    1.2   Addressing barriers to student learning and performance (including educational and psychosocial problems, external stressors, psychological disorders)

    1.3   Providing social/emotional support for students, families, and staff

2. Major Areas of Concern Related to Barriers to Student Learning

    2.1   Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity)

    2.2   Countering external stressors (e.g., reactions to objective or perceived stress/demands/ crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions)

    2.3   Teaching, serving, and accommodating disorders/disabilities (e.g., Learning Disabilities; Attention Deficit Hyperactivity Disorder; School Phobia; Conduct Disorder; Depression; Suicidal or Homicidal Ideation and Behavior; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities)

3. Type of Functions Provided related to Individuals, Groups, and Families

    3.1   Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets)

    3.2   Referral, triage, and monitoring/management of care

    3.3   Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, school-wide programs to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological first-aid; prereferral interventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short- and longer- term treatment, remediation, and rehabilitation)

    3.4   Coordination, development, and leadership related to school-owned programs, services, resources, and systems – toward evolving a comprehensive, multifaceted, and integrated continuum of programs and services

    3.5   Consultation, supervision, and inservice instruction with a transdisciplinary focus

    3.6   Enhancing connections with and involvement of home and community resources (including but not limited to community agencies)   (cont.)

4. *Timing and Nature of Problem-Oriented Interventions*

    4.1   Primary prevention
    4.2   Intervening early after the onset of problems
    4.3   Interventions for severe, pervasive, and/or chronic problems

5. *Assuring Quality of Intervention*

    5.1   Systems and interventions are monitored and improved as necessary
    5.2   Programs and services constitute a comprehensive, multifaceted continuum
    5.3   Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development
    5.4   School-owned programs and services are coordinated and integrated
    5.5   School-owned programs and services are connected to home & community resources
    5.6   Programs and services are integrated with instructional and governance/management components at schools
    5.7   Program/services are available, accessible, and attractive
    5.8   Empirically-supported interventions are used when applicable
    5.9   Differences among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses)
    5.10 Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences)
    5.11 Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion)
    5.12 Contexts for intervention are appropriate (e.g., office; clinic; classroom; home)

6. *Outcome Evaluation and Accountability*

    6.1   Short-term outcome data
    6.2   Long-term outcome data
    6.3   Reporting to key stakeholders and using outcome data to enhance intervention quality

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Note: As stressed above, considerable work is being done around the country related to developing standards, quality indicators, and accountability measures. For example, the State of Hawaii has integrated into its Standards Implementation Design for all schools standards and rubrics for *Quality Student Support* – http://doe.k12.hi.us/standards/sid.pdf   Another example is seen the efforts of the Center for School Mental Health Assistance to develop and research a quality assessment and improvement framework (for more information on this effort contact csmha@psych.umaryland.edu).